The Reorganised Health Service

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There are as many definitions of health and disease as there are societies. In the 18th century men finally jettisoned the punitive and exorcist remedies and nostrums of the medieval pharmacopaeia. In the 19th century a new orthodoxy was founded when medicine — institutionalised in the hospital and laboratory — made it its business to prevent, arrest or mitigate the effects of disease. That orthodoxy is now in crisis. We must decide whether to continue to pour ever more resources into the rigidly hierarchical, technologically sophisticated and exceedingly expensive medical machine or try to create a "health-promoting" society. The recent reorganisation of the health service in Scotland gives reason to hope that we can break the bonds of current orthodoxies and develop a new, more adequate system of health care organisation.

The first point to make, with regard to the development of health services in Britain, is that it has never been anything but a desperate uphill struggle. No one who has read the history of the 19th century health pioneers can doubt that the struggles of Chadwick, Simon, Florence Nightingale and others, against the inherited order of things, and against the "Defenders of the Filth", were both prolonged and bitter. In this century, was there not a moment in the history of the psycho-analytical movement when the **police** were invoked as the proper means of getting rid of the Freudian heresy? The fact is that health services, like health itself, have always had to be fought for. As Bevan said: "Governments claiming health services for their own are claiming medals won in battles they have lost."

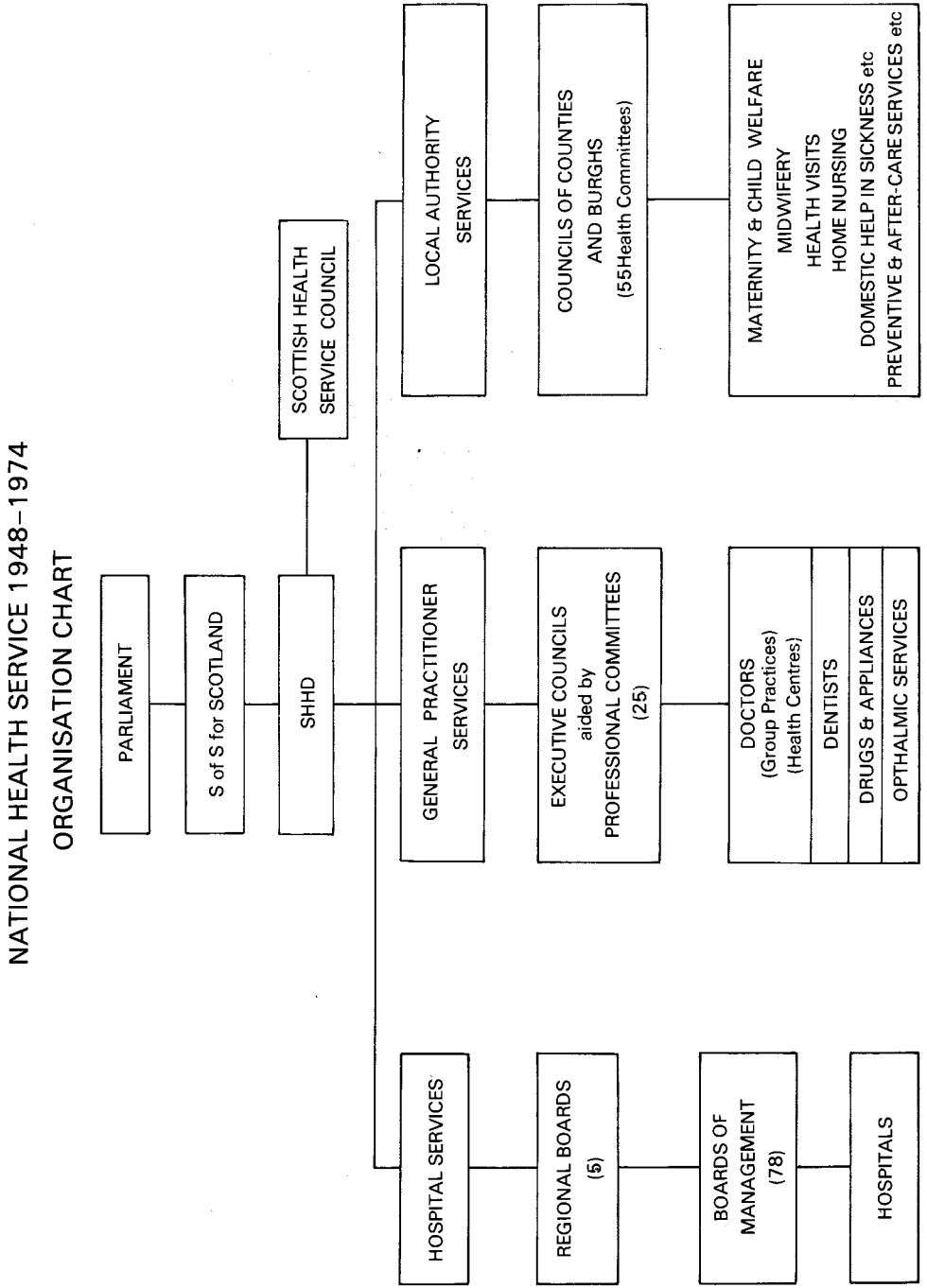
We are regaled with rumours and alarms about the current crisis in the NHS. No doubt it serves the purposes of different interest groups within the health care system to exaggerate the extent of any crisis that exists, as well as to suggest that it is an entirely new phenomenon. Some sensible comments on this issue can be found in the booklet "Health, Money and the National Health Service", which was published earlier this year by the Unit for the Study of Health Policy at Guy's Hospital. In so far as there is a crisis in the NHS, it is probably true to say that there has always been a crisis in health care in Britain.

In the past the crisis was a crisis of production, a crisis of **gross** shortages. Today the crisis is a crisis of distribution, a crisis of **relative** shortages. In short, what was a crisis of necessity and of constraint is now a crisis of choice and of priorities in a context of rising expectations and limited resources. In the age of the Poor Law, the classic equation, needs minus resources equals public health, was true in the most brutal, unqualified and absolute fashion. In the 19th century the right of health services to exist even on the periphery of society, as quasi-charitable entities, had to be painfully established. It was precisely because in the 19th century health services were not seen as part of the serious business of society, but rather as an affair of humanitarianism and Christian compassion, that they were left untouched by the new managerial and financial techniques which were beginning to dominate the industrial scene

Today the health care crisis not only involves infinitely more sophisticated and complex questions of ethics and priorities, but also has become a central issue in the affairs of the country; but it is the same crisis in a new form. Like other countries in the Western world, we in the UK have been subject, since the end of the Second World War, to a continuing crisis concerning the provision and organisation of health care. In Scotland, as in Britain generally, our first aim was to put health care on a systematic basis. Since the 1947 NHS (Scotland) Act was part of a general programme of nationalisation involving the railways, coal, gas and steel manufacturing, it reflected stable state, rational-efficient assumptions. One such assumption was Beveridge's maxim, that a health service would "diminish disease by prevention and cure", and ultimately it resulted, not so much in real health service , as in a mechanistic **sickness** service.

The 1948 Health Service was pre-eminently an aggregate of separate entities, artificially brought together into a single overall package. But it was not "born without ever having been conceived" and, in reality, the 1948 package was a good deal less rational and tidy than it appeared to be.

For all its imperfections, the 1948 model of the health service marked a turning point, in that it made health care available to the whole population without financial barriers and at the same time staked a continuing claim for resources for health care right at the centre of the governmental decision-making process. Moreover, in the years following upon its introduction, there was a substantial rationalisation through measures of make-do-and-mend of health care provision throughout the country. In



particular, although inequalities which are becoming increasingly difficult to justify still remain, key specialist skills were distributed more evenly than had ever been the case in the past.

1948-1974: The Search for Efficiency

After its inception in 1948 the evolution of the NHS, like the evolution of most complex systems, was mainly incremental and was only partly co-ordinated. The fact is that the stable state assumptions, on which it had been based, proved to be completely erroneous. Far from stabilising, the cost of health care escalated as the solution to one problem generated ten new ones. In consequence, since it had no strategy for coping with change, the 1948 model dealt with its problems by "putting on superfluous fat".

Only a few years after **Background and Blueprint** had given the new service its blessing, the Guillebaud Committee, with the help of Titmuss and Abel-Smith, pointed out that there was no level of health care which could be considered adequate, in any final sense. Indeed, with rising expectations and new advances in medicine, costs would be difficult to contain. Clearly Beveridge had been wrong to suggest that the new service would soon "pay its way". Clearly, too, when one considers the growing burden on the NHS at the present time, Mr Ian Mikardo, MP, had been wrong to say, in 1949, that the NHS had "made us into a healthy nation".

The Guillebaud Committee could see no remedy for the dilemma it had uncovered apart from the remedy of increased efficiency — and increased efficiency, involving a change of emphasis from administrative and procedural regularity to more dynamic managerial considerations, and from **fiscal,** or bookkeeping accountability, to **process** accountability — that is accountability in terms of value for money — became the watchword. But the collapse of the old certainties, and the existence of something like a vacuum of central leadership (the governmental machine, particularly in the pre-Fulton period, did not find it easy to adapt overnight to a managerial role), produced a situation of "disjointed incrementalism", in which there was no possibility of reconciling creativity and order. Central control was either arbitrary or non-existent and development on the periphery was inevitably hit or miss.

It was during the sixties, above all, that the NHS developed in an incrementalist and unco-ordinated fashion. In response to pressures from different groups within it, each of which set up a clamour for more resources, the service expanded. At the same time they often as not called for a "Health Service Beeching", who would be able to cut back on the "inefficient" expenditure of the other sectors. In the operational sphere, this system of "mutual partisan adjustment" generated ideas of multi-disciplinary functional management which led to the emergence of specialised nursing, administrative, works and hotel departments, not to speak of comprehensive medical divisions. At the same time the emphasis on operational efficiency within these functional departments resulted in an influx of work study, O. and M. and other efficiency experts. By 1973 the health service employed no fewer than 10,000 staff in new management services units, at an estimated annual cost of £6 million — a five or six-fold

increase in the number of such workers compared with the early sixties.

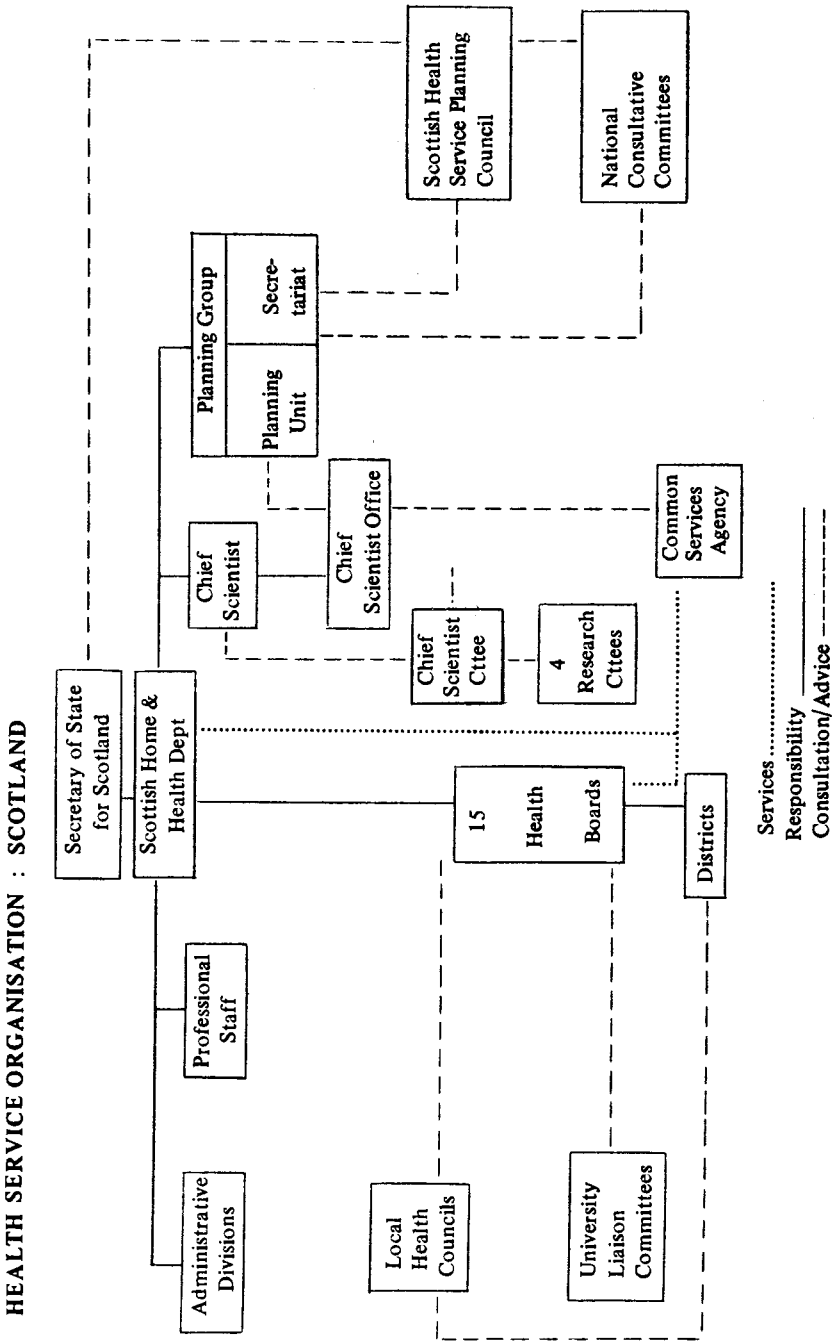
In its own self-adjusting way the NHS had become big business. Spending in Scotland alone in 1973-74, the last year before reorganisation, was £341,538,000 compared with £117,077,000 ten years before that — a **real** increase in health service expenditure of about 60%. In spite of all these developments, however, and although the health care system in the UK had a better record in terms of value for money than many other systems of health care, it became clear, during the sixties, that managerial efficiency at the operational level would not be enough to bring escalating costs under control. This situation was a prime determinant in the formulation of government policy in the late sixties, when a more fundamental solution to the difficulties and dilemmas of the NHS was proposed.

It was now accepted that, in order to resolve the difficulties which the health service was encountering, both in regard to rising costs and in regard to its inability to meet the growing needs of the elderly, the mentally ill and the mentally handicapped, structural reorganisation, involving clinical integration and managerial unification, must be superimposed on the existing structure. As indicated, reorganisation had two basic aims, which were not necessarily compatible. Indeed, whether these aims **could** be made compatible depended on the respective priorities accorded to them. On the one hand a restructured health service, with a built-in planning system, could simply be "more of the same", could simply be the final instalment of the efficiency and effectiveness era. On the other hand, reorganisation could be regarded as an attempt to eliminate the mismatch between what the NHS was doing and what it should be doing. Given the change in the pattern of illness from acute infections to chronic conditions, and from the disease men die of to those they have to live with, some change in the NHS was obviously needed. The 1948 NHS had been an illness service. Was it now time to create a **health** service which would maintain whole populations in health and which would give priority to care in the community instead of to cure in hospital?

The New Service

In England it is clear that what mattered in the period between 1968 and 1971 was **managerial control.** The central objective of the new service was to be effective management. In his introduction to the Consultative Document, which was issued in May 1971 and which foreshadowed the English White Paper and the subsequent Bill, the then Secretary of State, Sir Keith Joseph, saw the management part of the package as his special contribution and, in describing the proposals, said that their essence, and their basic difference from earlier proposals, was the emphasis which they placed on effective management.

In Scotland a more imaginative stance, which may have reflected the oft-repeated views of the CMO, Sir John Brotherston, was adopted. The remedy, even for escalating costs, was seen to lie less in managerial control than in a basic reorientation of the health service. Perhaps the first essential was to break away from the vicious circle of high technology



medicine and from Tudor Hart's "Inverse Law of Health Care". Whatever may have been the approach elsewhere, reorganisation in Scotland was not simply an attempt on the part of the government to regain control of a runaway health service through policies of increased centralisation. In fact the new structure is clearly centralised in certain respects; but it is much more than that.

As the organisation chart demonstrates, there has been a considerable degree of streamlining and centralisation. The reduction of 56 local health committees, 25 executive councils, five regional boards and 65 boards of management to a mere 15 Health Boards speaks for itself. However, it is the participative aspects of the new service, namely the Common Services Agency, the Scottish Health Service Planning Council, the National Consultative Committees, the Local Health Councils, the new ombudsman and the consensus style of management represented by Area and District Executive Groups that are crucial. These are to be the real growth points of the new NHS in Scotland, if it is to move in the direction of a paitent-centred service, backed up by a professional organisation.

The emphasis in Scotland was **clinical** not managerial. Reorganisation had two aims and those aims were stated in the following order:
(1) to integrate the personal health services "round the patient" — an old dream of Aneurin Bevan – by providing interrelated services to cope with interrelated problems, and to develop, so far as possible, a preventive community-based system of health care; and
(2) to provide these integrated caring and treatment services within a unified but supportive system of management, operating in the context of a flexible, anticipatory and participative planning process which would have a "cumulative" impact on the future development of the NHS in Scotland. This new approach to the health care crisis, involving a change of emphasis from efficiency and effectiveness to long-term strategic considerations, and from **process,** to **programme** accountability, has immense potential. But the fact that the future of the NHS, like the future of other organisations and institutions, must increasingly be a man-made future also presents the health professions, health administrators and the community itself with daunting problems and responsibilities.

For a future-orientated health service, managerial models drawn from concepts of "top-down" authority are inappropriate. But the new concepts of organisation more appropriate to human service organisation came into good currency in the UK only in the period 1966-71. So it was probably inevitable that both in Scotland, and in England and Wales (where use was made not only of McKinsey and Co. but also of the neo-scientific management, "building-block", approach of the Brunel Health Service Research Unit), reliance was placed on conventional, industrial-bureaucratic models. But whereas this was deliberate in the south, it is likely that in Scotland it was a case of hierarchy **faute de mieux.** In any event, whether it is because Scotland is still a homogeneous society with good communications, or whether it is because the Scottish tradition of democratic humanism is still something to be reckoned with, the Scottish

model of the reorganised NHS differed from the English and Welsh one by the extent to which it emerged as a participative model.

In England and Wales the bureaucratic structure of the new NHS was vigorously attacked before reorganisation and is now regarded by some commentators as a total mistake. In Scotland it is still possible to hope that Oliver Wendell Homes' famous remark to Harold Laski — never mind the **system,** tell me about the **insights** — can be adapted to meet the case of a formal structure which is not wholly congruent with the goals it has been set up to achieve but which is nevertheless redeemed by the incorporation of some imaginative participative mechanisms. Among these are the following:

(1) Local Health Councils (based on ideas first promulgated in the Wheatley Report and appearing in the reorganised NHS in England and Wales as "community health councils");

(2) the Common Services Agency;

(3) the National (and Local) Consultative Committees of the health care professions; and

(4) the Scottish Health Service Planning Council which is unique to Scotland and which advises the Secretary of State on the future development of the NHS in Scotland. It is a forum for shared decision-making, comprising, as it does, six senior administrative and professional officers of the Scottish Home and Health Department, and a representative from each of the 15 Health Boards and from each of the four medical schools in Scotland, all meeting under the impartial chairmanship of (at the present time) the Principal of Edinburgh University.

Given these participative mechanisms it is possible to believe that there is no going back in these matters and that we must work "in the interstices" of the technocracy in order to humanise it and make it more client-centred.

Still on this hopeful note, it can be said that the reorganised health service in Scotland at least has the potential to move fairly rapidly in the direction of a client-oriented service, based on **programme** accountability, which will involve us in developing, through the professional advisory system, not only comprehensive programmes of care for specific patient groups but also the cross-cutting service plans which will be necessary to meet the requirements of these programmes. The possibility exists, therefore, of a dramatic leap into the future. But in Scotland, too, one has misgivings lest the traditional elements in the new administrative structure should succeed in dragging the reorganised service screaming not merely into the pre-1948 era but actually into the 19th century. Instead of having been content to ask ourselves where we should be **going,** instead of having been content to "veer away from past failures", perhaps we should have given some thought to where, in the last quarter of the 20th century, we really ought to **be.**

It is too soon to say that, once again, we are driving into the future with the help of the rear mirror alone; but some of the problems and dilemmas which are now being encountered have an unmistakably familiar ring. They are certainly problems and dilemmas of dynamic conservatism, and of "fighting like mad to stay where we are", rather than problems and dilemmas of positive adaptation to new problems, new challenges, and new opportunities.

One could instance as examples of these all-too-familiar difficulties, the stresses even in Scotland (which has one tier fewer than England and Wales) between the different levels of the hierarchical management structure. Also there is a problem simply because it is a hierarchical structure, of the movement of administrators of quality towards the top of the pyramid. It is this upward movement which has produced a situation of "the administration with the hole". It is a forcible reminder that the relationship between the old Boards of Management and the Regional Boards was a **collateral** relationship rather than a superior-subordinate one. One could also mention the health-social work dichotomy, the communication problems which have arisen between Local Health Councils and Health Boards in some parts of the country and the rivalries of professionals and bureaucrats which are inherent in all hierarchical structures. There also seems to be a marked tendency to hark back to procedural regularity, when what is called for is increased flexibility, increased informality, and an increasing emphasis on the real goals of the health care system. To be sure, it may be too soon to say that these regressive tendencies are merely a temporary and, to some extent, a reassuring phenomenon. In a period of increasing complexity and change, dynamic conservatism has a key part to play in keeping the system from flying apart at the seams. One can only reiterate that there are participative mechanisms in the Scottish model, which make it possible for us to view the reorganised NHS not as our final destination but merely as a better starting point than the 1948 one ever was.

What the chrysalis of the new NHS can yet evolve into is an open system, or arena, of health care. One in which, once artificial authority barriers have been eroded, the tapping of our new potential for working together can begin to rank as the first priority. Is it possible to envisage a "negotiated order" in the health care system, with professionals acting in supportive ways in regard to other professionals in the multidisciplinary settings of health care teams? Can we envisage such health care teams interlocking with and supporting other teams, so that the periphery of the health care system starts knitting itself together into a series of flexible, "self-transforming networks"? Finally, can we envisage these peripheral, or operational, networks, however "shadowy" they may be in the first instance, being linked to, and even overlapping with, central supportive networks? If so, in time and in a cumulative way, we can begin to plan and co-ordinate networks not only of health services, but also of health related services like social work, housing and education.

Our hope must be that the momentum of change will carry us over some

of the reefs and shallows, and over some of the deeper gulfs and undercurrents, which at present block our passage to the open sea, and that, before too long, we shall be able to achieve the sophisticated levels of provision which are now at least possible of attainment. All this having been achieved, however, will it actually constitute a real breakthrough? Or will it merely be yet another "veering away from past failures"? Will it still be a health service based on the question: "Where should we be **going**?" instead of on the question, "Where should we **be**?" Will it still be a health service that is concerned with negative, as distinct from, positive prevention and with our "limping" rather than with our "walking"?

Towards an Alternative Health Care Model

Merely to ask these questions is to open up new horizons and to suggest the need for a genuine reversal of perspectives, leading to an alternative model of health care. Health is not something we have had and lost. It is not something which can be restored to us by hospitals and clinics. We do not have a health industry in the sense that we can manufacture health. As a recent Scottish Home and Health Department publication said, "It is a paradox of the present system that so much is spent on ineffective cure while so little is done to encourage the public in general to improve its own health" (1976). Health, in short, has less to do with health services than with life-chances and life-styles. It is the life-styles of individuals in society, and the life-style of society as a whole, that are decisive.

It has been said that modern medicine is on the edge of a Copernican Revolution and that doctors are awaiting a single turn of thought, comparable to knowing that the earth is not flat, before medicine can take a new direction.

Self-help, self-health, the community itself as doctor do these concepts indicate the real way ahead? Of course, community development at this level of intensity is not a realistic expectation at present but perhaps it is not too far over the horizon, particularly if one is prepared to accept what Julia Abrahamson has said in "A Neighbourhood Finds Itself": "In the people of every community everywhere there is a vast untapped potential, almost limitless energy and resources which can be released for community betterment. Freeing that potential and channelling it into constructive citizen action can provide a powerful source of strength in the saving of our cities and the regeneration of the nation."

The social anthropologists have described societies in which community care was a major ingredient in health care and it seems that, once again, community involvement is the Archimedes point giving us the leverage on the world which we need for the next great advance. Industrialisation destroyed our small village communities with their intricate community support systems. In doing so it also introduced concepts of prevention in terms of which disease could be averted or avoided since it was no longer a visitation or a punishment for some breach of taboo or sin or transgression. But the rationalistic proponents of negative prevention, and of a "sanitated society", went too far in proposing that disease could be totally eradicated

by "health services".

Health promotion policies and policies of positive prevention aim at integrating both of these approaches, first, by recreating the village on a national (or global) scale and, secondly, by reinforcing, through the statutory health care system, the potential of the community, under conditions of post-industrialism, for self-help and self-health.

It is ironical that, after all the agonised to-ing and fro-ing, both in Scotland and in the rest of the UK, about the reorganisation of the NHS — a reorganisation which it is to be hoped will not be found to have saddled the community with an even more technocratic system of health care than that which existed between 1948 and 1974 — the real clue to the future is almost certainly to be found in those developments in health care which are now being pioneered in the Third World.

The focus of this paper is on the reorganisation of the NHS in Scotland. Yet "society itself is the real patient" and health services do not, in fact, manufacture health. Ninety-five per cent of our improved health over the last 200 years has come, not from medical intervention (which has contributed 5 per cent or thereabouts and that only since the thirties) but from general social advance. So it may now be permissible to speculate about the **deorganisation** and debureaucratisation of health care.

Health services are an indispensable (although increasingly costly and, in some respects, increasingly dangerous) **resource.** But, central to the quality of life in modern society, is the concept of self-health in the context of a health-promoting society (Unit for the Study of Health Policy, 1976). The implications of this concept for a materialistic, divisive and inegalitarian society are now the "strategic factor". In industrial psychology Herzberg has distinguished between the "hygiene factors", without which men cannot work at all, and the "motivating factors", which inspire them to give of their best. Ingeniously equating Herzberg's "hygiene factors" with the role of hospital-based health services and his "motivating factors" with community self-help and concepts of self-health, Michael Wilson has written a book called "Health is for People" (1975). Even more apposite perhaps, and certainly more germane to the theme of this paper, is the title of a recent WHO publication (1976) which reports on some of the remarkable self-help advances in health care which have taken place through techniques of "simplified medicine" in the Third World in communities so apathetic and "spiritless" that they often seemed beyond recovery. Conveying, according to Morris Carstairs, "something new and important, and in plain language", this book is called "Health By the People".

We do not really have a new health service in Scotland. What we have is a health service which is constantly evolving and which, at the present time, is in a state of fairly rapid transition and development. It is impossible to predict — and it is really anyone's guess — how political devolution, if it becomes a reality, will retard or accelerate the processes of deorganisation and debureaucratisation of health care, which have been mentioned above.

Following upon the administrative deconcentration which took place

earlier this century, there is a certain logic in political devolution; and, in terms of classical political theory, such devolution **should** have a beneficial impact on the administration of all the services for which the Scottish Office is responsible. Equally, however, if one may be the devil's advocate, political influence on the administration of health services has often had baneful consequences. What we must hope, however, is that it is not macro-politics of the party-political type but rather micro-politics of the community type — direct contact with the patient and the community through "participative", as distinct from "representative", institutions — that will constitute the lifeblood of a health care system. Nor can any of the political parties maintain that, in the event of devolution, their chief aim would be to "de-politicise" health care in Scotland, because "taking the NHS out of poltics" merely means taking it out of the other man's politics and bringing it into one's own .

Still in the role of the devil's advocate, one could go further and suggest that the attempt to find a 19th century macro-political solution for Scotland's present-day economic and social problems could, in itself, represent the single most vivid manifestation, on the current scene, of dynamic conservatism in action. The historian, Maitland, saw the relationship of Scotland and England, from the 16th century on, as a dynamic one, involving both increasing economic centralisation and increasing cultural decentralisation. It is certainly important to appreciate that issues of centralisation and decentralisation can be only too easily over-simplified. The impact of devolution on the Scottish NHS, as on other areas of our national life, **could** be negative rather than forward-looking.